



Exploring Medicaid Health Homes Leveraging Care Coordination Organizations in Medicaid Health Homes: The Washington Way

September 12, 2013; 2:00 – 3:00PM (ET)



Exploring Medicaid Health Homes

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Health Home Information Resource Center

Technical Assistance for State Health Home Development

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance led by Mathematica Policy Research and the Center for Health Care Strategies includes:
 - One-on-one technical support
 - Peer-learning collaboratives
 - Webinars open to all states
 - Online library of hands-on tools and resources, including:
 - Matrix of Approved Health Home SPAs
 - Map of State Health Home Activity
 - New draft SPA template

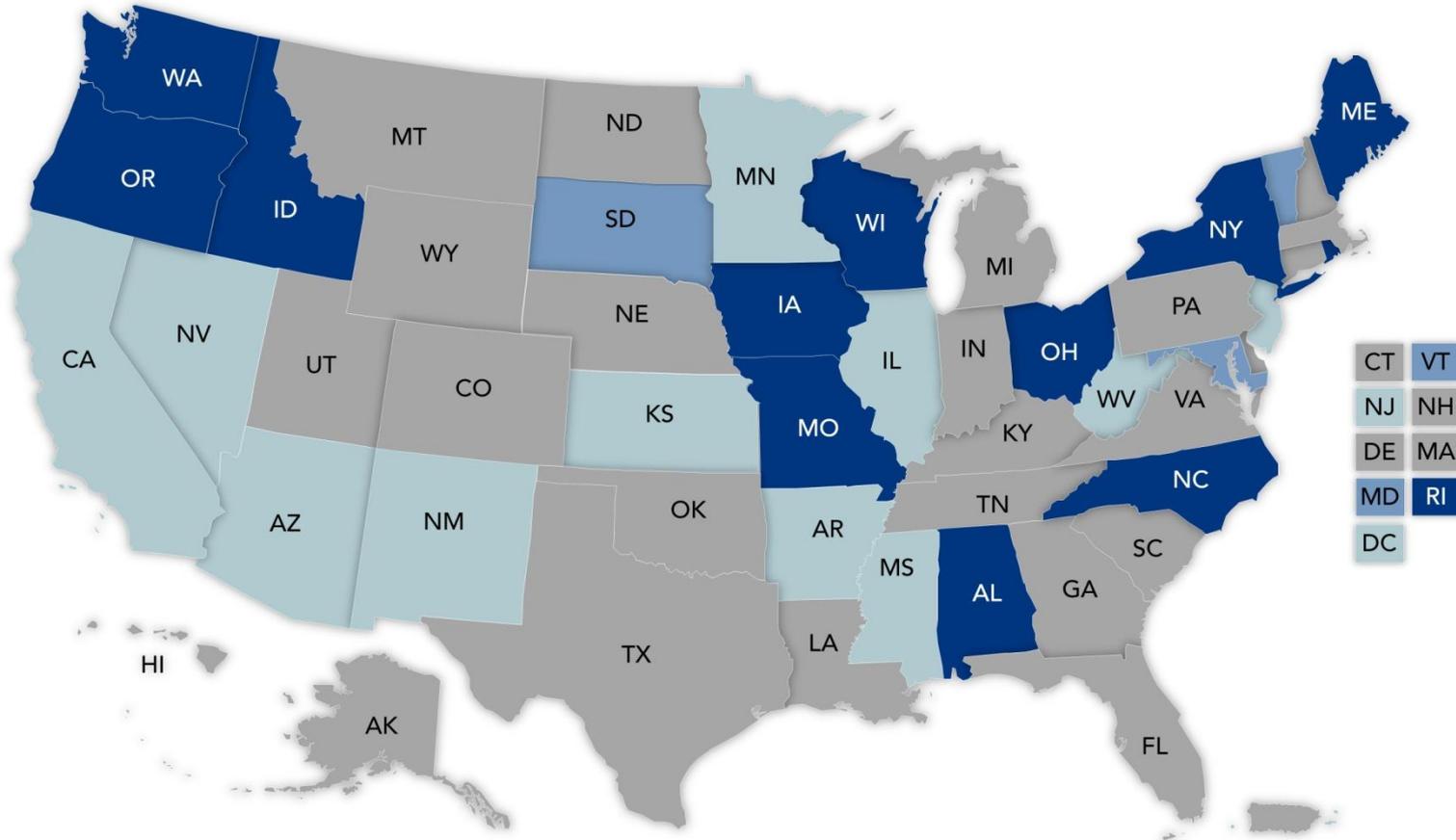
Exploring Medicaid Health Homes Webinar Series

- Provides a forum for states to share models, elements of their SPAs, and successes or challenges in their development process
- Creates an opportunity for CMS to engage in conversation with states considering and/or designing health home programs
- Disseminates existing knowledge useful to health home planning
- Open to any state considering or pursuing health homes

National Landscape to Date

- 17 approved State Plan Amendments in 12 states: AL, IA, ID, ME, MO, NC, NY, OH, OR, RI, WI and WA
- Number of states in discussion with CMS
- Many other states exploring the opportunity to develop health homes

State Health Home Activity

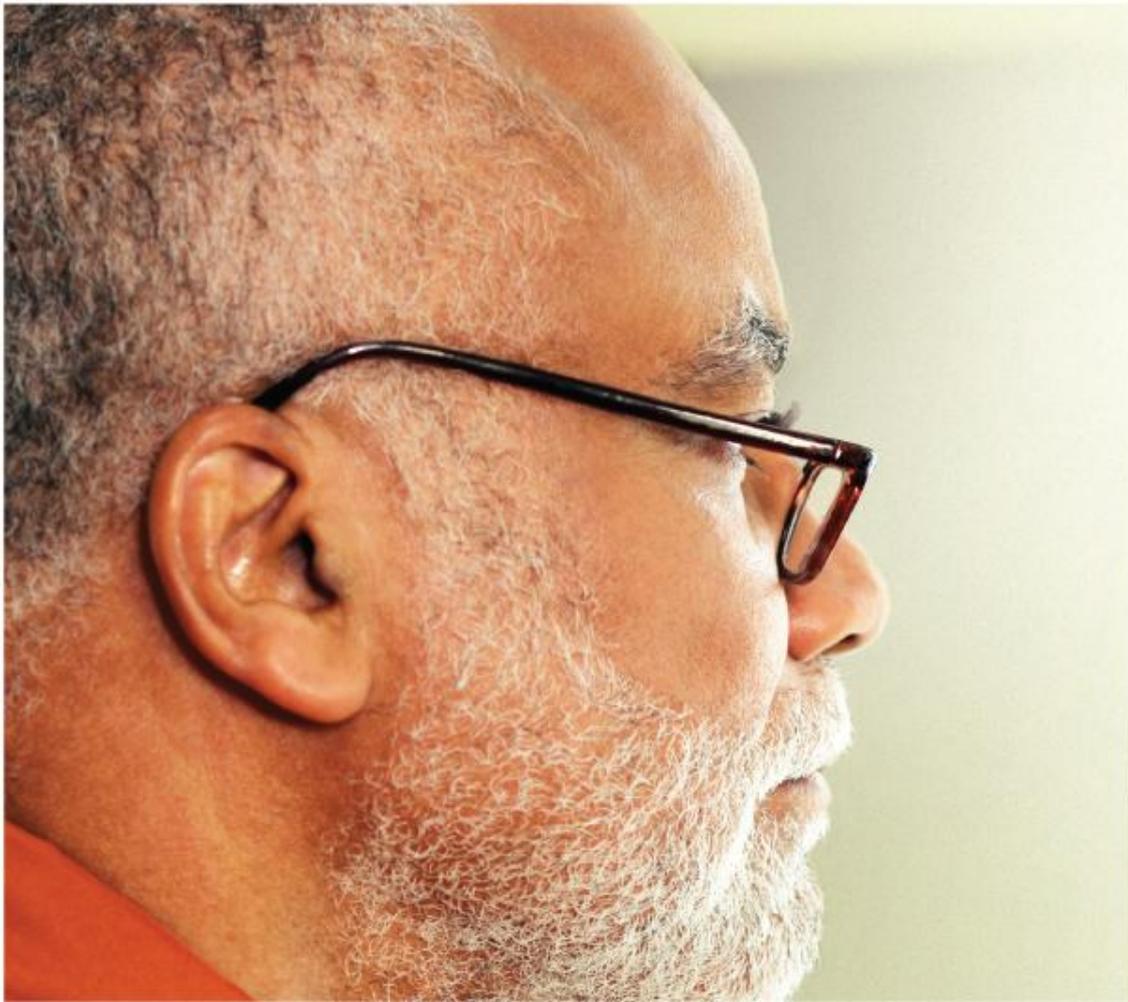


CT	VT
NJ	NH
DE	MA
MD	RI
DC	

Approved Health Home State Plan Amendment (SPA)	Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Washington, Wisconsin
Health Home SPA "On the Clock" (officially submitted to CMS)	Ohio (2 nd SPA), Maryland, South Dakota, Vermont (response to Request for Additional Information (RAI) pending)
Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, West Virginia, Wisconsin
No Activity	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wyoming

Context for Washington

- Washington Medicaid – building upon care coordination organizations and coordinating with duals demonstration
- Today's presenters
 - Becky McAninch-Dake, Project Manager, Grants and Program Development, WA Health Care Authority
 - Karen Fitzharris, Project Director, Duals Financial Alignment, WA Department of Social and Health Services



Health Homes The Washington Way



Washington's Medicaid program

- Health Care Authority
- Managed care
- Five managed care organizations
- Statewide
- Blind/disabled population moved from FFS to managed care in July 2012

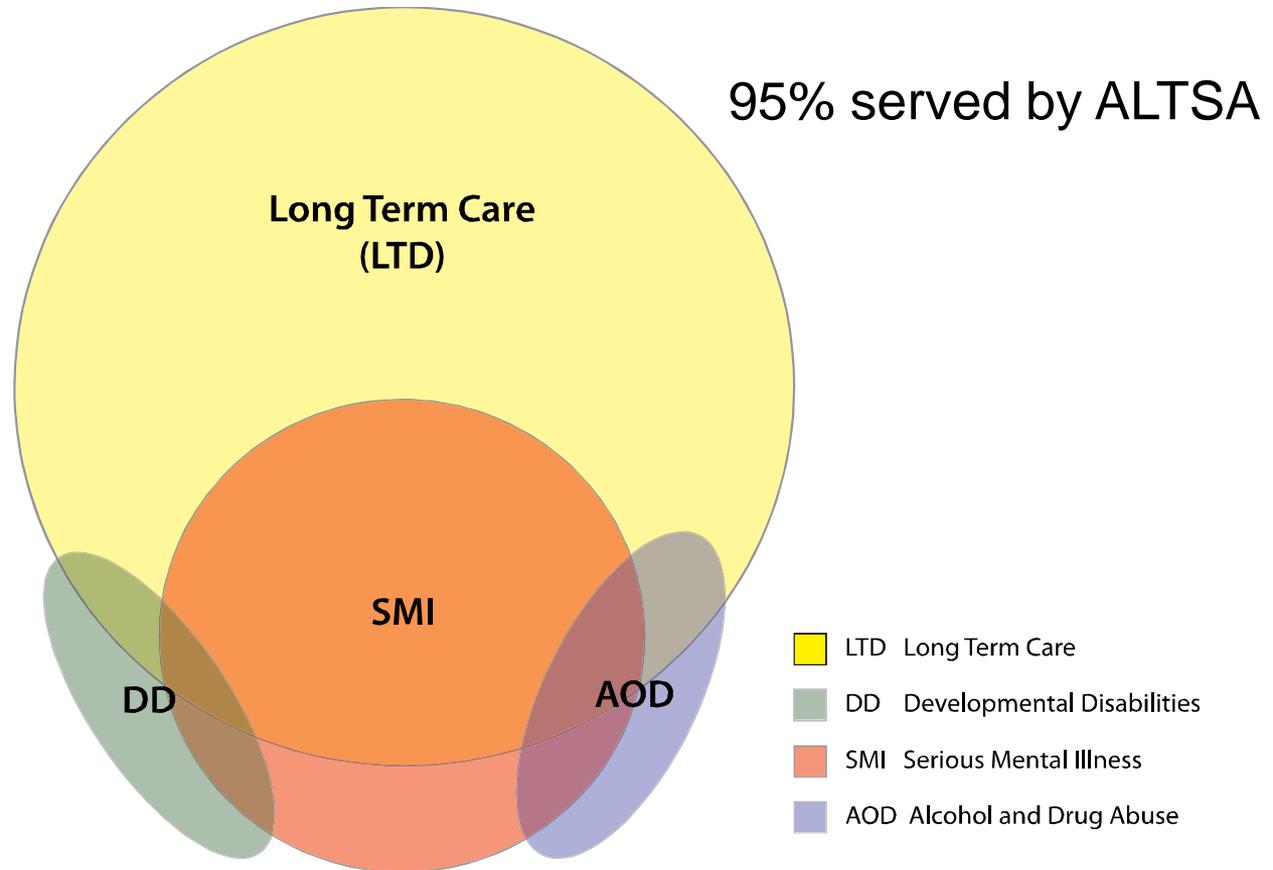


Health Homes



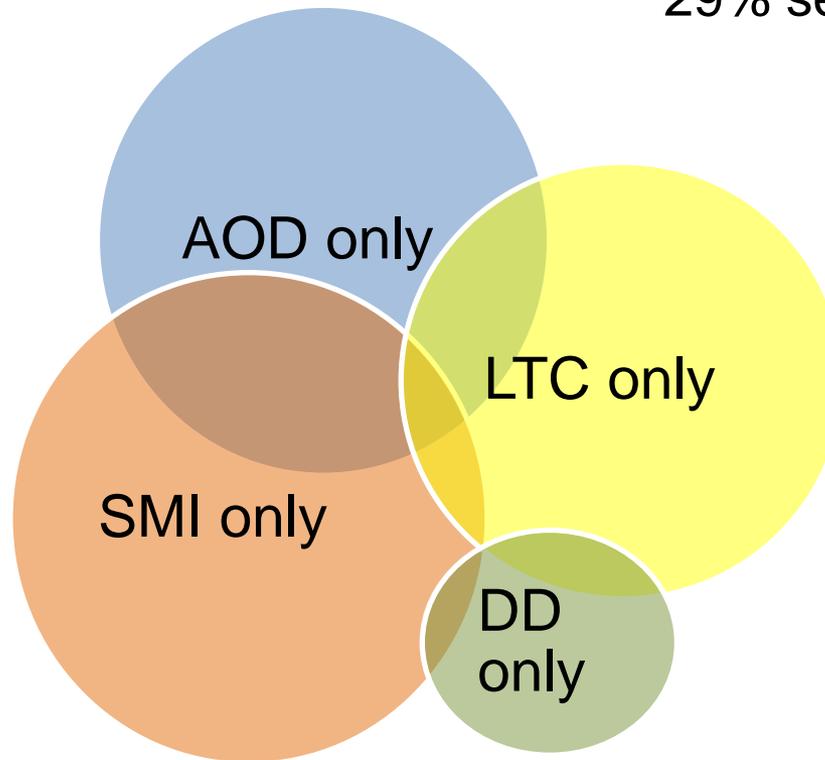
Why Bother?

Service Needs Overlap for High Risk/High Cost Beneficiaries who are Eligible for Medicare & Medicaid



Service Needs for High Risk/High Cost Medicaid-Only Beneficiaries Overlap

29% served by ALTSA



State Strategies for Integrating Care Include...

- Trial and error
- Embed robust delivery of Health Home services in all systems

Sources that Inform Washington's Health Home Model

- Federal law – Section 2703, Accountable Care Act
- State law – SSB 5394 (passed in 2011)
- Stakeholder feedback during “Duals” planning
 - Improve coordination and align incentives
 - Single point of contact and intentional care coordination
 - Improve on what works, including flexibility to allow for local variances based on population need and provider networks

Managed Fee- For-Service

How does it fit in?



Managed FFS (MFFS) Financial Alignment Demonstration

- Health homes are a natural vehicle for aligning the delivery of care in the FFS population
- Duals Financial Alignment Demonstration



HealthPath
Washington

Washington State
Health Care Authority



Benefits

- Structure already in place through State Plan Amendment
- Potential to sustain the program after 90/10 match can no longer be claimed
- Ability to add additional resources through the use of infrastructure grants
- Coordinated services bridges the existing fee-for-service system
- Access the right care, at the right time and place

Challenges

- Different rules, different measures, more resources needed
- Agreement and signatures on the Final Demonstration Agreement
- Agreement and signatures on the State Plan Amendment
- Communication challenges
- Delays in funding
- Performance Measures

Health Homes

Implementation Approach



Goals

- Establish person-centered health action goals designed to improve health, health-related outcomes and reduce avoidable costs
- Coordinate across the full continuum of services
- Organize and facilitate the delivery of evidence-based health care services
- Ensure coordination and care transitions
- Increase confidence and skills for self-management of health goals
- Single point of contact responsible to bridge systems of care

Focus on High Risk Enrollees

- Most at-risk for adverse health outcomes
- Greatest ability to achieve impacts on hospital and institutional utilization, and mortality
- Most likely to need/receive multiple Medicaid paid services
- Cost effective / achieve a return on investment
- Need to achieve funding sustainability for these interventions

Eligible Beneficiaries

- Identified chronic condition
- All ages, proportionally more individuals impacted among duals, than SSI Blind Disabled and traditional Healthy Options
- Statistically higher Emergency Department use, hospitalization and re-hospitalization
- A risk score of 1.5 or greater

PRISM & Risk Scores

At risk of a second chronic condition is a minimum predictive risk score of 1.5. The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group, the WA SSI disabled population.

Services

- Health Action Plans driven by the individual
- Health Action Plans support self-management – Patient Activation Measure & Caregiver Activation Measure (PAM/CAM)
- Health Action Plans belong to the Health Home enrollee
- Use of Health Information Technology

Health Home Coverage Areas

Coverage Area #2

NWRC – FFS Only
 CCC – Managed Care Only
 Molina – Managed Care Only
 UHC – both FFS and Managed Care
 CHPW – both FFS and Managed Care
 Effective 10.1.2013

Strategy 2 – Medicare/Medicaid Integration Project (Managed Care)
 Regence Blue Shield and UnitedHealthCare
 Voluntary Enrollment 5.1.2014 and Passive Enrollment 7.1.2014

Coverage Area #6

Community Choice – FFS only
 CCC – Managed Care Only
 Molina – Managed Care Only
 UHC – both FFS and Managed Care
 CHPW – both FFS and Managed Care
 Effective 10.1.2013

Coverage Area #1

Optum – FFS Only
 CCC – Managed Care Only
 Molina – Managed Care Only
 UHC – both FFS and Managed Care
 CHPW – both FFS and Managed Care
 Effective 10.1.2013

Coverage Area #5

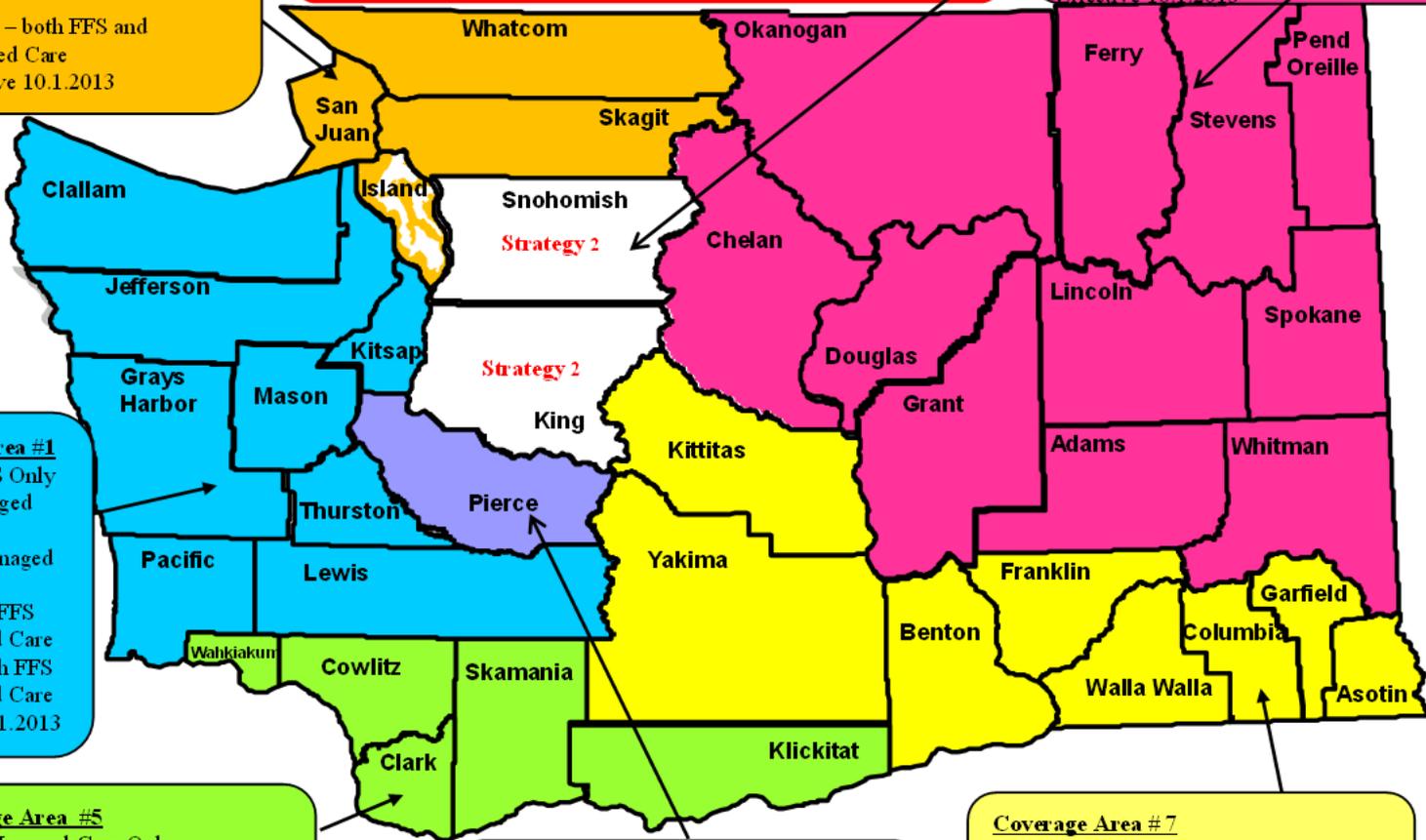
CCC - Managed Care Only
 CHPW & UHC - both Managed Care and FFS
 OPTUM - FFS Only
 Effective 7.1.2013

Coverage Area #4

CCC & CHPW - Managed Care Only
 UHC - both Managed Care & FFS
 Optum - FFS Only
 Effective 7.1.2013

Coverage Area #7

CCC & CHPW - Managed Care Only
 UHC – Managed Care and FFS
 OPTUM & SE WA ALTC - FFS Only
 Effective 7.1.2013



6/25/2013 REV

Available Population High Cost/High Risk Duals by Coverage Area

Area	Count
1	5,330
2	5,510
3	9,613
4	5,100
5	3,265
6	6,223
7	4,273
State	39,314

Qualification Process

- An application and process developed for 3 phase roll-out to qualified health homes.
- Released in November 2012, February 2013 and May 2013.
- Emphasis on creation of community partnerships, expert care coordination staff, outreach and high touch services delivered in community setting including a beneficiary's home.

Payment for Health Home Services

- \$252 for outreach, engagement and health action plan
- \$172 for intensive care coordination services
- \$67 for maintenance
- Health plans pass share of payment to network entities who provide care coordination services
- Fee-for-service: Payment to lead entity that passes share of payment to entities who provide care coordination services

Washington's Math to fund FFS health homes

- Increased Federal financing for first 8 quarters
- State financing current match will be enhanced by 40%
- The added match will be used to leverage FFS HH individuals



Next Steps

- 2nd SPA submittal for October 1, 2013 start dates for remaining coverage areas
- Finish readiness reviews and on-site visits for new Qualified Leads
- Train Care Coordinators
- Sign contracts
- Enroll eligible population into Qualified Leads
- Take a deep breath and
- Continue to work on Strategy 2, 3-way Capitated/Integration Management Care

Resources

Websites:

http://www.hca.wa.gov/health_homes.html

<http://www.adsa.dshs.wa.gov/duals/>

<http://www.integratedcareresourcecenter.com/>

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Karen Fitzharris – Fitzhkm@dshs.wa.gov

For More Information

- Download practical resources to improve the quality and cost-effectiveness of Medicaid services.
- Subscribe to e-mail updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.